

October 5, 2004  
Amended October 6, 2004

MDR Tracking #: M2-05-0023-01  
IRO Certificate #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### RECORDS REVIEWED

These include the \_\_\_ preauthorization request summaries, responses from the previous reviewers, communications from \_\_\_, medical dispute resolution requests, TWCC 73 reports, 261 initial medical report, chiropractic spinal x-ray report, 03/03 lumbar spine MRI, records and progress notes from \_\_\_, \_\_\_ function capacity evaluation from June 2003, the initial consultation and other reports from the \_\_\_ / \_\_\_, \_\_\_, case summary and appeal of \_\_\_, dated 08/09/04.

#### CLINICAL HISTORY

This patient is a 53-year-old former police officer with the \_\_\_, who sustained an injury on \_\_\_ when he fell into a large unseen ditch at a crime scene. The ditch was filled with grass and water. He fell in a splits-type position and has subsequently undergone work-up and multiple periods of treatments.

Thus far, he has not responded to treatments. He has been treated by \_\_\_, a pain management specialist. At this time he suffers a fairly severe chronic pain syndrome with much depressive component also.

This patient has a past history of hernia and bilateral knee surgery. He had ten years of military service prior to entering his several-year police career.

A pain management program has been requested. There was a primary denial per the review by \_\_\_. The report of 07/21/04 reveals denial judgment concerning no previous group therapy, lack

of psychotropic medications, other- and medical necessity at that time was denied. A second \_\_\_\_ review is noted with a second denial. The date was not clearly printed, possibly 9/ or 8/16/04, but was based on the same rationale.

#### REQUESTED SERVICE

A thirty-session chronic pain management program is requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

This patient has undergone a sufficient amount of primary/secondary treatment programs and attempts. This case does, at this time, warrant the proposed chronic pain management program. Of particular note, rather convincing, is the eight-page appeal document of 08/09/04 prepared by \_\_\_\_\_. This patient is now \_\_\_\_ months post injury and remains extremely dysfunctional. At this time there is justified medical necessity of the proposed chronic pain management program for this patient, and the likelihood of it being significantly beneficial is strong.

\_\_\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

#### YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision,** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions,** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 5th day of October, 2004.**